Hospital Trustee Guide:
Physician Relations, Recruiting, and Retention

Introduction

Among the topics with which hospital Board members must be familiar is physician staffing. Physician staffing typically includes three primary elements: physician relations, recruiting, and retention.

As the hospital considers its role in these areas, it is necessary to first develop an understanding of the current physician market. Who are doctors today? How many are there? What are their concerns? In what settings do they practice? How are they now being affected by health reform and shifting market dynamics? With multiple changes pending this year and beyond, how is their role in the health system likely to change?

The unique position of physicians in the health system and the various elements of physician relations, recruiting and retention are reviewed in this paper, prepared by Merritt Hawkins, the nation’s leading physician search firm and a company of AMN Healthcare (NYSE: AHS), the largest healthcare staffing organization in the United States and the innovator of healthcare workforce solutions.
Part One: The Physician Market

As the Board considers its role in physician relations, recruiting and retention, it is necessary to first develop an understanding of the current physician market. Who are doctors today? How many are there? What are their concerns? In what settings do they practice? How are they now being affected by health reform and shifting market dynamics? With multiple changes pending in 2016 and beyond, how is their role in the health system likely to change?

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The Most Powerful Tool in Healthcare

Despite the many technological and policy changes that have occurred in healthcare in recent years, physicians remain at the center of the health system. An examination of hospital physician relations, recruiting and retention begins with an acknowledgement of this important fact. It is physicians who admit patients, order tests, prescribe drugs, develop treatments, perform procedures and discharge patients. The majority of activities impacting both patient care and revenue within the hospital begin or end with a physician’s signature, and this is unlikely to change regardless of what direction the health system takes.

It is for this reason that many consider the most powerful tool in healthcare to be the physician’s pen (or, increasingly, the physician’s mouse).

The ability of a hospital to effectively work with, recruit and retain physicians often determines the extent to which it can fulfill its mission to provide quality care and to remain financially viable. Physician relations, recruiting and retention therefore are key priorities for virtually every hospital in the United States.

The Physician/Hospital Relationship

Board members should be aware that historically the relationship between physicians and hospitals has not always been harmonious and has long been characterized as an “uneasy truce.”

Physicians and hospitals have traditionally formed an arm’s length alliance, with true integration often proving elusive. As the number of hospitals increased in the early 1900s, physicians began to practice in a “workshop” model, treating the hospital as an extension of their offices. Because the doctors were the keepers of scientific knowledge and generated revenue for hospitals, they had a unique and paramount role. One example of this influence and autonomy is that the American College of Surgeons in 1918 adopted minimum standards for surgical environments, and hospital leaders followed them. As part of the requirements, hospitals were compelled to develop formal medical staff structures and medical staff policies to supervise hospital standards.
Since that time, hospitals have shared the authority to provide care with physicians, with two separate domains: physicians overseeing clinical matters at the individual patient level and policing themselves through peer credentialing, while administrators oversaw non-clinical hospital operations to meet needs at the community level. The hospital provided a place to treat patients, and the technology and support staffs to care for them and in return expected that physicians would serve in non-paid medical staff positions and hospital committees. All of these factors, perhaps, set the stage for difficulties in hospital-physician relations in later years.

The 1990s saw a wave of efforts to integrate hospitals with physicians, including joint ventures, physician-hospital organizations and physician practices purchases on the part of hospitals. The impetus for this movement was the belief that managed care—in which insurers negotiated with a limited panel of hospitals and physicians—would be the prevailing model of coverage. When demand for managed care ebbed in the late 1990s, many of these partnerships disbanded, in some case suffering from a lack of commitment from physicians and/or a lack of management expertise from hospitals.

While these previous moves to integrate were aimed largely at gaining bargaining power, recent attempts to align physicians and hospitals usually are initiated for the purpose of creating better quality metrics and more efficient operations with an eye toward participating in payer contracts that reward quality/efficiency performance. Health care reform encourages these alignments through pilot projects, such as those using bundled payments, those promoting shared savings contracts with Accountable Care Organizations, and those supporting formation of Patient Centered Medical Homes.

Until recently, both physicians and hospitals have operated in a “fee-for-service” environment and have been paid on the basis of volume of services, with more tests and procedures conducted leading to higher reimbursement. In what may be a fundamental change, the health system currently is in the process of moving away from paying for volume and toward rewarding physicians and hospitals on the basis of value, i.e., the quality of care they provide for the associated cost. As part of this change, hospitals and physicians are in some cases taking on risk previously assumed by health insurance companies.

Whether this transformation can be fully achieved, however, has yet to be demonstrated. For the present and likely for at least several years to come, hospitals and physicians will to a significant extent be rewarded on the volume of services they perform.

Some of the services that physicians perform drive revenue directly to their affiliated hospitals. These services include patient admissions and the diagnostic tests, laboratory tests, treatments and procedures that physicians order or perform.

Merritt Hawkins quantifies the average annual revenue that physicians in various specialties generate on behalf of their hospitals through our Survey of Physician Inpatient/Outpatient Revenue. Results of this survey are indicated below.
Average Annual Revenue Generated by Physicians for Hospitals

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Revenue</th>
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</thead>
<tbody>
<tr>
<td>Orthopedic surgery</td>
<td>$2,746,605</td>
</tr>
<tr>
<td>Cardiology (invasive)</td>
<td>$2,448,136</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>$2,445,810</td>
</tr>
<tr>
<td>General surgery</td>
<td>$2,169,673</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>$1,830,200</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>$1,688,056</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>$1,583,209</td>
</tr>
<tr>
<td>Family Practice</td>
<td>$1,493,518</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>$1,422,677</td>
</tr>
<tr>
<td>Urology</td>
<td>$1,405,659</td>
</tr>
</tbody>
</table>

Average for all physicians: $1,560,688

Source: Merritt Hawkins 2016 Physician Inpatient/Outpatient Revenue Survey

These numbers underline the fundamental importance of physicians to hospitals from a financial perspective. This revenue contributes to the hospital’s viability and hence its effectiveness in carrying out its mission of service to the community.

A Growing Shortage

While physicians are a primary resource for hospitals, the Board should be aware that doctors today are in increasingly short supply. The Association of American Medical Colleges (AAMC) forecasts that by 2025 the nation will face a deficit of up to 90,400 physicians.

Physicians are not distributed evenly throughout the population, and consequently shortages tend to be concentrated in rural or inner city areas or in central regions of the country away from the coasts. Physicians and their spouses often locate to communities where other professionals live, choosing a practice based on lifestyle considerations rather than patient demand for their services in a particular area. In many cases, physicians seek locations where spouses also can obtain professional employment, creating a maldistribution of physicians that further exacerbates the physician shortage.

The Health Services and Resources Administration (HRSA) currently designates over 6,000 Health Professional Shortage Areas (HPSAs) for primary care nationwide, in which over 65 million people live.

The causes of the physician shortage are various and include:

- **A growing population:** The U.S. population increased by 36% between 1980 and 2010, adding more than 82 million people, and is projected to increase from about 310 million today to 346 million by 2025 (Deseret News, May 2016).
An inadequate supply of new physicians: While the population increased by 36% from 1980 to 2010, the number of physicians trained in the U.S. increased by only 8%.

An aging population: People 65 years old or older represent the fastest growing demographic segment in the United States. By 2025, the number of people 65 and older in the United States is expected to increase by 41% (Deseret News, May 2016). Older patients visit a physician at three times the rate of younger physicians, accelerating demand for physician services.

Changing physician practice styles: Physician work hours declined from an average of 57 per week in 1977 to 53 per week in 2012, as doctors embraced a more a "controllable lifestyle" featuring set hours and regular vacations. The reduction in average hours had the effect of reducing the physician workforce by 36,000 full-time equivalent (FTE) physicians (Source: Journal of the American Medical Association, Feb. 24, 2010-Vol 303, No 8). The influx of women into medicine also is having a dramatic effect on physician supply, as female physicians work 8% fewer hours per week than do male physicians.

Increased innovation: Medical devices, drug treatments, and surgical procedures are proliferating at a rapid rate, fueling demand from an increasingly health conscious population.

Given the turnaround time to train a physician (11 year or more) the challenge of physician shortages will persist for the foreseeable future.

All aspects of physician relations, recruiting and retention, therefore, proceed from the underlying fact that there is a dearth of candidates in today’s market and that physicians are at a premium.

As the Board evaluates and examines the physician market, this is a primary consideration to keep in mind.

An Evolving Workforce

Who are physicians today?

Fifteen to 20 years ago, this question could be easily answered, as physicians were a demographically homogeneous group practicing in a relatively uniform way. In the past, physicians could be characterized as white, male, U.S. trained, independent business owners practicing in solo or small group settings.

That is no longer the case today. Increasingly, physicians are likely to be female, Asian, internationally trained employees of hospitals, large medical groups or other institutions.

It is important for Board members to have an understanding of the evolving nature of the physician workforce to ensure the efficacy of its physician relations, recruiting and retention plans.
Below is a breakout of the current physician workforce nationally.

**Physician Demographics (United States)**

<table>
<thead>
<tr>
<th>Total Physicians in Patient Care</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>214,412</td>
<td>29%</td>
</tr>
<tr>
<td>Foreign Medical School Graduates</td>
<td>205,053</td>
<td>24%</td>
</tr>
<tr>
<td>Board Certified</td>
<td>641,149</td>
<td>86%</td>
</tr>
<tr>
<td>Research</td>
<td>12,570</td>
<td>2%</td>
</tr>
<tr>
<td>Administrative/Teaching</td>
<td>22,966</td>
<td>3%</td>
</tr>
<tr>
<td>Final Year Residents</td>
<td>30,611</td>
<td>4%</td>
</tr>
</tbody>
</table>

| Age 0-35 | 155,607 | 21% |
| Age 36-45| 226,490 | 31% |
| Age 46-55| 215,054 | 29% |
| Age 56-65| 193,464 | 23% |
| Age 66+  | 97,452  | 13% |
| Unknown  | 1,677   | <1%  |

**Total physicians: 889,744**

These numbers illustrate several physician workforce trends of which Board members should be aware. Over 36% of all active physicians in the U.S. are 56 years old or older. Certain medical specialties are particularly top-heavy with older doctors and shortages in these specialties are likely to be exacerbated as physicians retire (see chart below).

**Physician 56 or Older**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Psychiatry</td>
<td>56%</td>
</tr>
<tr>
<td>Oncology</td>
<td>54%</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>52%</td>
</tr>
<tr>
<td>Urology</td>
<td>46%</td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td>43%</td>
</tr>
<tr>
<td>Cardiology (non-inv)</td>
<td>42%</td>
</tr>
<tr>
<td>General surgery</td>
<td>42%</td>
</tr>
<tr>
<td>Radiology</td>
<td>42%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>40%</td>
</tr>
</tbody>
</table>

Some 33% of all active U.S. physicians are female. Twenty-four percent of all active physicians in the U.S. received their medical education overseas.

A dwindling number of doctors fit the physician profile of yesterday. It consequently is important for hospitals to embrace a wide range of physician candidates and to focus on qualities such as medical training, communication and bedside manner rather than age, gender or national origin. This concept is explored in more detail in the section of Recruiting and Retention.
What are Their Concerns?

Just as physician demographics have changed in recent years, how physicians view medical practice also has changed. In reviewing hospital physician relations, recruiting and retention programs, the Board should consider the current medical practice environment from the physicians’ perspective.

Increasingly, physicians have grown dissatisfied with many of the factors they must contend with in the course of their practices. Their concerns and attitudes have been revealed in a variety of surveys, including three surveys conducted by Merritt Hawkins on behalf of The Physicians Foundation, a non-profit grant-making organization of medical society leaders (www.physiciansfoundation).

Following are several responses to these surveys reflecting the attitudes and concerns of today’s physicians:

**How do you feel about the current state of the medical profession?**

<table>
<thead>
<tr>
<th>How you feel</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very positive</td>
<td>8.8%</td>
</tr>
<tr>
<td>Somewhat positive</td>
<td>35.6%</td>
</tr>
<tr>
<td>Somewhat negative</td>
<td>37.1%</td>
</tr>
<tr>
<td>Very negative</td>
<td>18.5%</td>
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</tbody>
</table>

**How do you feel about the future of the medical profession?**

<table>
<thead>
<tr>
<th>How you feel</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very positive</td>
<td>10.2%</td>
</tr>
<tr>
<td>Somewhat positive</td>
<td>38.7%</td>
</tr>
<tr>
<td>Somewhat negative</td>
<td>39.5%</td>
</tr>
<tr>
<td>Very negative</td>
<td>11.6%</td>
</tr>
</tbody>
</table>

**Would you recommend medicine as a career to your children or other young people?**

<table>
<thead>
<tr>
<th>How you feel</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>50%</td>
</tr>
<tr>
<td>No</td>
<td>50%</td>
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</table>

*Source: Physicians Foundation 2014 Survey of America’s Physicians – Practice Patterns and Perspectives*

A primary reason for physician dissatisfaction revealed by surveys cited above centers on the issue of autonomy. Many physicians feel they no longer are able to control how they practice and how they are reimbursed.

Third party payers such as Medicare dictate physician fees, and Medicare reimbursement rates have been flat or have trended downward for many types of physicians in recent years. Through treatment protocols, pre-authorizations and other methods, private insurance companies can dictate to physicians the treatments they are able to provide to their patients. The threat of malpractice keeps physicians continually on edge.
In addition to these concerns, physicians are challenged by the increased difficulty of running their practices. The conversion to electronic medical records, necessary to maintain Medicare reimbursement, is expensive and time consuming. Compliance with a wide range of government regulations pertaining to employment, worker safety, privacy, and many other issues create administrative, legal and cost burdens many private practice physicians are unable to sustain.

As a result, a growing number of physicians are seeking alternatives to traditional, independent medical practice, or are planning to opt out of patient care roles altogether. The responses below to The Physicians Foundation survey cited above underlines this trend.

**Consider your practice plans over the next three years.**

**Do you plan to:**
- Continue As I Am: 56%
- Cut Back on Hours: 18%
- Retire: 9%
- Switch to Concierge: 6%
- Work Locum Tenens: 9%
- Cut Back on Patients Seen: 8%
- Seek a Non-Clinical Job Within Healthcare: 10%
- Seek Employment with a Hospital: 7%
- Work Part-Time: 6%
- Close My Practice to New Patients: 2%
- Other: 5%

*Source: Physicians Foundation 2014 Survey of America’s Physicians – Practice Patterns and Perspectives*

As the survey indicates, only 56% of physicians indicated they plan to maintain their current style of practice. The remaining 44% plan to take one or more steps likely to reduce their role in patient care, by retiring, cutting back on the number of patients they see, working part-time, pursuing a career outside of medicine or taking other steps.

The concerns and attitudes of physicians today present both challenges and opportunities to hospitals seeking to enhance their physician relations, recruiting and retention programs. Board members who can promote medical practice environments that address the concerns of today’s doctors can significantly enhance their hospitals’ ability to provide high quality, cost-effective care. This topic is addressed in more detail below in the section on retention.

**The Effect of Health Reform**

The Patient Protection and Affordable Care Act (i.e., “health reform”) is having a dramatic impact on all
stakeholders in health care, including physicians.

In 2010, Merritt Hawkins convened a panel of health care experts on behalf of The Physicians Foundation to review how health reform would affect physicians specifically. Panel members included leaders of academic institutions, practicing physicians, practice managers, attorneys and others. Analysis and data resulting from this meeting are included in the nationally noted white paper Health Reform and the Decline of Physician Private Practice. Below are some of the conclusions outlined in the white paper:

- The independent, private physician practice model will be largely, though not uniformly, replaced.
- Most physicians will be compelled to consolidate with other practitioners, become hospital employees, or align with large hospitals and health systems for capital and technical resources.
- Emerging practice models will vary by region – one size will not fit all. Large, Accountable Care Organizations (ACOs), private practice medical homes, large independent groups, large aligned groups, federally qualified health centers (FQHCs), concierge practices, and small aligned groups will proliferate.
- Reform will drastically increase physician legal compliance obligations and potential liability under federal fraud and abuse statutes.
- Reform will exacerbate physician shortages, creating access issues for many patients. Primary care shortages and physician maldistribution will not be resolved. Physicians will need to redefine their roles and rethink delivery models in order to meet rising demand.
- The imperative to care for more patients, with higher perceived quality, at less cost, will put additional stress on physicians, particularly those in private practice. Some physicians will respond by opting out of private practice or by abandoning medicine altogether, contributing to the physician shortage.

Since the panel convened, these projections have largely proven to be accurate. Health reform is reshaping how physicians practice, leading to a variety of new practice models of which Board members should be aware, though some existing models remain in place. Current physician practice types are summarized below.

**Physician Practice Types**

Physicians can be organized in a variety of ways and these practice models can influence how physicians relate to the hospital. Practice types include:
Small, Independent Practice

As stated above, privately owned medical practices is no longer the dominant model, but some 200,000 physicians remain independent practice owners, responsible for generating income, hiring and managing staffing, and overseeing office operations (or hiring practice managers to do so). These physicians typically will establish admitting privileges to one or more local hospitals and may perform services at the hospital or hospitals. They also may serve on hospital boards, provide coverage for the emergency room, and act as medical directors or department heads, for which they may receive a stipend. Hospitals traditionally assist independent groups with the expense of physician recruiting, including paying for recruiting services and providing an initial salary or income guarantee for newly recruited physicians. Over the next five years, independent practices are likely to see more structural change than any other practice type.

Large, Integrated Multi-Specialty Practices

The model features large groups of physicians who practice in multiple clinic locations and are integrated with a hospital or hospitals also run by the group. The Mayo Clinic, The Cleveland Clinic and Scott & White in Texas are examples of this model. In some large practices, such as Mayo, physicians are paid a straight salary and do not earn bonuses based on seeing more patients or other volume based metrics. This incentive structure is intended to allow physicians to spend more time with patients and focus on quality outcomes rather than revenue generation.

Hospital-Employed Physicians

As stated above, many physicians have found the traditional private practice model to be untenable and have embraced employment by a hospital or medical group. The transformation of physicians from private business owners to employees has been rapid. In 2004, only 11% of Merritt Hawkins’ physician recruiting assignments featured hospital employment of the physician. By 2016, that number has grown to 49%.

According to the Medical Group Management Association (MGMA), the percent of physicians employed by a hospital or integrated delivery system grew from 37% to 47% (a 74% increase) from 2006 through 2011, while the number employed by physicians dropped from 64% to 41% (a decrease of 36%). The consulting firm Accenture projects that by 2016, fewer than one-third of U.S. physicians will remain independent, down from 57% in 2000 (see chart below).

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>2000</td>
<td>57%</td>
</tr>
<tr>
<td>2005</td>
<td>49%</td>
</tr>
<tr>
<td>2009</td>
<td>43%</td>
</tr>
<tr>
<td>2013</td>
<td>37%</td>
</tr>
<tr>
<td>2016</td>
<td>33%</td>
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</table>

Source: Accenture
Many physicians embrace hospital employment because it provides the security of a regular paycheck, alleviating private practice physicians’ concerns about fluctuations in reimbursement and the difficulties of collecting what they bill. They no longer have to focus as much energy on “running a business” and can devote more of their energies to patient care.

However, with employment comes a more “corporate” mindset in which physicians, like other employees, adhere to a set schedule and enjoy other benefits such as vacation time – a departure from the “old school” ethic in which physicians often considered medicine an all-encompassing way of life. Some physicians worry about losing clinical autonomy in employed settings, while hospital administrators are concerned that employed physicians will not be as productive once they are on set salaries.

Physician employees of the hospital are listed as a W-2 employee on the hospital’s payroll, and benefits are also included. Typically, an employment contract will feature a base salary with a production bonus. Physician salaries and bonuses are discussed in more detail in the section on Recruiting and Retention.

Health Maintenance Organizations (HMOs)

HMOs are organizations that provide insurance and managed care for individuals and employees of companies contracted with the HMO. Unlike traditional indemnity insurance, an HMO covers only care rendered by those doctors and other clinicians who have agreed to treat patients in accordance with the HMO’s guidelines and restrictions in exchange for a steady stream of patients.

Some HMOs require members to select a primary care physician to act as a “gatekeeper” to direct access to medical services. Except for medical emergencies, patients need a referral from a primary care physician in order to see a specialist or other doctor. Generally, the gatekeeper cannot authorize a referral unless the HMO guidelines de it necessary. “Open access” HMOs, however, do not use gatekeepers.

HMOs operate in a variety of forms, and many today do not fit one form but may have multiple divisions operating out of different models. In the “staff model” physicians are salaried, have offices in HMO buildings, and are direct employees of the HMO. This model generally is “closed-panel,” meaning physicians can only see HMO patients. In the “group model,” the HMO does not employ the physician directly but contracts with a multi-specialty physician group practice. Individual physicians are employed by the group practice rather than the HMO. The group practice may be established by the HMO and only serve HMO members. This is known as the “captive group model.” An HMO also may contract with an independent medical groups (the “independent group model”), or independent practice associations (IPAs), which usually will continue to treat non-HMO patients.

Medical Homes

The Patient Centered Medical Home is a practice model in which a physician leads a team of clinicians in the delivery and coordination of all of a patient’s healthcare services. Rather than the disjointed model that now characterizes health care delivery, in which care is delivery in various “silos” (hospital inpatient beds, the emergency room, rehabilitation centers, laboratories, etc.) patients benefit from more seamless care,
generally coordinated by a primary care physician.

Both the federal government and various private insurers have sponsored medical home pilot projects, which have demonstrated the ability to reduce costs, improve care, and decrease physician burn-out. The concept relies on a robust electronic medical record component that allows doctors to track the quality of care they are achieving for patients. Practices must meet quality criteria to become recognized as medical homes through the National Committee for Quality Assurance (NCQA). The number of medical homes appears likely to grow as the NCQA receives about 165 new medical home applications a month.

**Accountable Care Organizations**

While the health reform law encourages clinical integration as exemplified by the medical home through various pilot projects, the most direct encouragement of service integration is accomplished through the Medicare Shared Savings Program for Accountable Care Organizations (ACOs). In these Medicare projects, which began in 2012, provider organizations such as hospitals and medical groups that meet specified quality standards and accept accountability for patients are able to share saving with the government. Private insurance companies also have sponsored ACOs.

ACOs also are dependent on robust, integrated information technology systems through which all participating providers are connected. Perhaps the most essential component in this model, however, is effective physician-hospital alignment. Both hospitals and physicians must share the same patient care goals and be able to agree on both levels of reimbursement and how savings will be shared. Board members of hospitals considering ACO status or acting as ACOs should pay particular attention to how well the interests and perspectives of physicians and the hospital are aligned.

Below is a list of several prominent health care organizations that have been accepted as Pioneer ACOs by the Medicare Shared Savings Program.

**Accepted as Pioneer ACOs**

- North Texas ACO
- Seton Health Alliance
- Allina Hospitals and Clinics
- Banner Health Network
- Park Nicollet Health Services
- University of Michigan
- Beth Israel Deaconess
- Tarrant, Parker, and Johnson counties
- Central Texas, including Austin
- Minnesota and Western Wisconsin
- Phoenix
- Minneapolis
- Southeastern Michigan
- Eastern Massachusetts

**Concierge Practices**

As reimbursement declines, administrative time required for billing increases, and treatment pre-authorizations and other factors listed above erode physician satisfaction, primary care physicians and even some specialists have found an alternative to traditional private practices: Concierge-style practice. In these practices, physicians limit their panel of patients and charge them directly with a monthly fee. Third party
payers such as Medicare or private insurers are eliminated as doctors contract directly with patients.

In exchange, patients can have more interaction with their doctors, such as unlimited and longer appointments, and access to physicians by phone and email. Some concierge physicians will even accompany their patients to the hospital.

The American Academy of Private Physicians, a professional organization of direct care providers, estimates the current number of concierge physicians at over 5,000. This is a small number, but such physicians were virtually unknown until several years ago. This type of practice may become much more prevalent in affluent urban and suburban areas where patients have the resources to pay monthly or yearly fees in exchange for more personal care.

While concierge practices may be able to deliver an enhanced quality of care, they effectively reduce the overall physician workforce, as concierge patients often reduce the number of patient they see from several thousand a year to as few as several hundred. Board members of hospitals where concierge practice is expanding should monitor how this trend is affecting access to patient care in the service area.

Community Health Centers

Federally Qualified Health Centers (FQHCs) are a linchpin in the nation’s healthcare delivery system, providing care in underserved areas, both rural and urban, and to those who are poor, uninsured and underinsured.

FQHCs, numbering 1,300 with about 9,000 delivery sites, are already the largest network of safety net primary care services in the nation. FQHCs received a considerable funding boost both through the Obama stimulus package and through health care reform, and will receive over $10 billion in extra funding over the next several years.

Traditionally, FQHCs have drawn from the National Rural Health Corps when recruiting medical staff. However, because FQHCs offer many of the amenities today’s physicians are seeking, including an employed setting, minimal hospital call, reduced malpractice risk and other benefits, they are likely to appeal to a broader range of physicians in the future.

Board members should be aware of FQHC services available in their communities and determine if there are methods for creating closer ties to these safety net providers. As more patients rely on community centers, primary care physicians are likely to play a larger role as admitters to their local hospitals. Working together, hospitals and FQHCs may be able to enhance prevention, reduce hospital readmissions and achieve related quality of care goals.

Hospital Affiliated Groups

Rural areas have traditionally been a bastion of independent, private physician practice. However, even smaller medical groups in rural communities are feeling the pressure to align with a larger “big brother”
(typically a hospital or health system) to provide them with administrative, financial and recruiting support. In these arrangements groups may sell to the hospital but continue to have control of practice decisions through a clinic operations committee on which they serve as majority members. The practice may be owned by the hospital though the physicians are employed by a separate, larger medical group that also may be affiliated with the hospital or the hospital’s parent system.

To ensure continued access to services, Board members of rural facilities should determine the current state of independent local medical practices and explore ways in which the hospital can ensure their continued viability.

**Joint Ventures**

In order to align with physicians, hospitals sometimes will enter into joint ventures, in which a hospital and physician or physician group will the share the cost of opening and maintaining generally outpatient or off-campus sites of service, such as surgery centers. In these arrangements, physician/hospital cooperation is encouraged as both parties have “skin in the game.”

**Urgent Care Centers**

Urgent care centers offer high-quality care for common illnesses and non-life threatening procedures such as sprains, broken bones, flu, colds, infections, cuts, and other common illnesses or injuries. They typically are staffed by primary care physicians and advanced practice professionals.

Urgent care centers have an advantage over hospital emergency departments as they can choose patients by payer type and may elect not to see Medicaid or uninsured patients if these patients are not able to pay upfront. Hospital emergency departments, by contrast, are obligated by law to see all comers. While some states require urgent care centers to be licensed, most do not.

Typically, urgent care centers are open seven days a week with evening and weekend hours. According to Becker’s Hospital Review, 85% of urgent care centers are open seven days a week with 95% closing after 7 p.m. The average cost of treatment is $150, and most participate with major insurance plans. Urgent care centers, once dismissed as “doc in the boxes,” now are a $14.5 billion business (see “Race is on to Profit from Urgent Care Centers, Julie Creswell, New York Times, July 9, 2014).

As physician practice models proliferate, physician relations, retention, and recruiting are becoming more complex, as strategies and incentives may vary from one model to the next. Board members are advised to learn the nuances of the practice models in their hospitals’ service areas and the advantages and disadvantages to the hospital of each.
Part Two: Physician Recruiting and Retention

Hospitals are tasked with meeting the health needs of their communities, and for this they need physicians. What are the best strategies for recruiting and retaining physicians? With what federal physician regulations must hospitals comply? What are the latest trends in physician compensation? And how can hospital Board members ensure their facilities are well positioned to recruit and retain the most appropriate physician candidates?

These questions are examined in more detail in this section.

An Ongoing, Sequential Process

Physician recruiting and retention, like almost all other aspects of health care, have changed dramatically in recent years, increasing in both complexity and difficulty. Thirty years ago, physician recruiting often was an ad hoc process. Hospitals would react to a need as it arose and usually fill the position on their own, by using the personal network of its medical staff, by leveraging its relationships with local teaching hospitals, or through other internal resources. The person assigned to this task generally had a range of other operational or administrative duties. Outside recruitment firms might be used for particularly challenging searches where candidates were few, such as surgical or pediatric subspecialties.

Today, all but the smallest hospitals generally have at least one full-time physician recruiter on staff. Larger facilities and systems have multiple employees solely engaged in physician recruitment. In addition, there are hundreds of outside firms in the industry who provide supplementary resources in permanent and temporary physician recruiting.

For many hospitals, the physician recruiting process is no longer an ad hoc endeavor. Rather, it is an ongoing process which incorporates physician retention and physician recruiting in a continuous cycle.

In Merritt Hawkins’ experience, developed over 25 years of working with hospitals of all sizes, effective physician recruiting is based on a specific sequence of steps that build the groundwork for consistently successful results.

Many of these steps take place “beneath the surface” -- that is, before physician recruiting candidates are contacted or interviewed. For this reason, we refer to the sequential process of physician recruiting as the physician recruiting “iceberg.” Each step is important to laying the groundwork for success and no step should be omitted. The concept is illustrated below:
The Physician Recruiting “Iceberg”

Success!
Follow-up
Closing
The Interview
Candidate Screening
Establishing Parameters
The Incentive Package/Contract
Assembling the Recruiting Team
Objective Opportunity Analysis
Ensuring Regulatory Compliance
Strategic Staff Plan/Needs Analysis
Physician Search Cost/Benefits Analysis
Ongoing Physician Retention/Relations Plan
Knowledge of the Current Physician Market

Board members committed to enhancing their hospitals’ physician recruiting and retention success should have at least some familiarity with each of these components, starting at the base of the “iceberg” and moving up until positive results are achieved.

Step One: Market Knowledge

The topic of physician market knowledge was addressed above but is briefly reiterated here. Board members and hospital administrators must consider general market conditions as they guide their facilities through the search process. In general, it is a buyer’s market in physician recruiting today, as physicians in most specialties are able to choose from a number of different opportunities.

This trend is illustrated by a survey Merritt Hawkins conducts looking at the practice preferences and career plans of final-year medical residents about to enter the job marketing. Below is a question and a key finding of the survey:

*How many times during the course of your training were you contacted about job opportunities by recruiters?*

<table>
<thead>
<tr>
<th>Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 10</td>
<td>12%</td>
</tr>
<tr>
<td>11 to 25</td>
<td>11%</td>
</tr>
<tr>
<td>26 to 50</td>
<td>14%</td>
</tr>
<tr>
<td>51 to 100</td>
<td>17%</td>
</tr>
<tr>
<td>Over 100</td>
<td>46%</td>
</tr>
</tbody>
</table>
As the survey indicates, 63% of medical residents completing their training received 50 or more job solicitations during their training, while almost half received over 100 job solicitations.

Because of its highly competitive nature, the only way to be successful in today’s environment is to approach physician recruitment with a great sense of urgency and commitment. Today’s market dictates the application of a strategic plan, multiple resources and continuous focus to the physician recruiting process.

**Step Two: Physician Retention**

If market knowledge and a focused mindset are at the “base” of the physician recruiting iceberg, physician retention is not far behind. Because physicians are in such short supply, the best way to “recruit” physicians is to hold on to those you already have.

Following are key points for Board members to consider when evaluating their hospitals’ physician retention program.

**The physicians “workshop”**

Physicians leave a community or a hospital for a variety of reasons. Some of them revolve around family matters or other factors beyond the hospital’s control, creating attrition that may be as unexpected as it is unavoidable.

As a general rule, however, physicians are pushed rather than pulled out of their practices. They usually do not leave because physician recruiters tempt them with extravagant incentives. Rather, something unsatisfying about their practice environment causes them to look for greener pastures. Board members should therefore do what they can to ensure that the medical practice environment at their facility is as physician-friendly as possible.

Following are some ways to maintain a premier physician “workshop.”

- Maintain a qualified, appropriate nursing staff. A key irritant to many physicians is lack of appropriately trained nurses
- Improve physician access to patient data
- Enhance test turnaround times
- Ensure timely, efficient OR capability
- Ensure timely, efficient patient admissions and release
- Enhance ER triage/patient turnaround
- Implement a hospitalist/surgicalist/laborist/nocturnist program
- Provide flexible scheduling
Use locum doctors during peak usage periods to avoid physician burn-out.

Provide convenient parking/access for physicians.

Maintain appropriate equipment/electronic medical records.

Add specialty support as needed.

Maintain a quality medical staff. Physicians are very sensitive to the training and professionalism of their peers.

Like snowflakes, no two practices are alike. Some practices are more appealing than others, not necessarily because they are located by a beach or the mountains, but because they feature a practice style and a work environment tailored to what doctors today prefer. You cannot control the fact that you are not close to an ocean, but you can to some extent control the quality of the medical practice environment you are offering.

First and foremost, physicians are looking for environments where they can provide quality care to their patients. Though it is not always easy or inexpensive to do so, it is important to maintain a premier practice environment so that physicians see no need to seek greener pastures.

Medical staff surveys

If you want to know how physicians on staff feel about their practices, you have to ask them. Part of this process includes conducting a yearly physician satisfaction/retention survey. The survey will seek to elicit physician pain points, recruiting needs, equipment needs, marketing needs, specialty support, retirement plans and ways in which the facility can assist them.


Sound recruiting practices

Physician turnover often takes place because of lapses in the initial recruiting effort. If expectations regarding hours, group governance, quality of care, financials and related issues are not clearly communicated on the front end during recruiting, misunderstandings that lead to turnover can result on the back end. The hospital should spell out in writing exactly what is expected of the physician, and make sure to accurately project the financial potential of the practice so that expectations are realistic.

Formalize follow-up

It is natural when a recruiting project is completed to go on to the next challenge. Unfortunately, a physician who has been the subject of considerable positive attention can quickly come to feel neglected and uncertain about his or her position. A regular schedule of one-on-one meetings should be conducted to avoid this at 30, 90, 180 and 365 days. It is important to stress that these meetings are not performance evaluations—they are a friendly attempt to learn how the physician and his family are fitting in.
Move toward integration/employment

As referenced above, health reform and market forces are promoting the integration and consolidation of hospitals, medical groups and individual physician practices. Today, physicians usually want to be aligned with hospitals that are responding to this trend. Facilities are promoting physician integration in a number of ways, including:

- By employing physicians featured hospital employment of the physician
- Offering gain sharing/joint ventures
- Forming ACOs/medical homes
- Offering physicians leadership development opportunities

The push toward more integrated delivery systems (including ACOs), and the desire of many doctors to seek relief from the burdens of private practice, are likely to accelerate the integration process, which, though difficult, may result and closer physician/hospital cooperation and enhanced physician retention.

Pay for emergency department call

ED call may be a part of the hospital’s physician employment agreement. If not, or if independent physicians are on staff, paying for ED call can be a good retention tool. The daily ED call pay rate for physicians in various specialties is tracked by the Medical Group Management Association’s (MGMA) Medical Director and On-Call Compensation Survey (call MGMA at 303-799-1111 for a copy of the survey).

Learn when they leave

It is disappointing to lose a physician from the staff, but a doctor’s departure can be a learning experience. Schedule exit interviews with departing physicians to understand their motivations and to gain insight into what policies and procedures you may need to adjust.

The “Three C’s” – Communication, Communication, Communication

Above all else, physician retention is a matter of communication. Several years ago, Merritt Hawkins recruited a neurologist and subsequently contacted him to see how he was fitting in with a new group practice. He informed us that he was leaving because the hospital had not put his name on the door and on other signage, and he therefore assumed he was not wanted. A simple lapse in communication almost caused this group to lose a good doctor.

Physician communication should be both:

- Formal, through regular medical staff surveys, and
- Informal, through regular contact in the physicians’ lounge, at lunch, in the operating room, or at informal gatherings such as “pizza conferences” or “ice cream conferences” which both administrators and Board members may wish to attend.
This thought is best encapsulated in as quote from a health system CEO that further reiterates the importance of communication:

“When you need the goodwill of physicians, it is too late to create it. My advice is get ahead of the competition by having a really good relationship with your doctors.”

**Step Three: Cost/Benefits**

It is important for the Board to understand the resources that must be allocated to physician recruitment and how expending these resources can be justified. Physician recruitment has become an increasingly expensive proposition. Hospitals must be more financially competitive as the candidate pool gets tighter, and must spend more to identify potential recruits. The chart below illustrates the projected cost of recruiting a family physician today.

<table>
<thead>
<tr>
<th>Cost Breakdown</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary or income guarantee</td>
<td>$225,000</td>
</tr>
<tr>
<td>Benefits/Perks</td>
<td>$50,000</td>
</tr>
<tr>
<td>Recruiters fee (in-house or agency)</td>
<td>$25,000</td>
</tr>
<tr>
<td>Candidate sourcing</td>
<td>$10,000</td>
</tr>
<tr>
<td>Candidate/Spouse interview</td>
<td>$3,000</td>
</tr>
<tr>
<td>Physician relocation</td>
<td>$10,000</td>
</tr>
<tr>
<td>Practice marketing</td>
<td>$3,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$326,000</strong></td>
</tr>
</tbody>
</table>

While this is a considerable outlay, on average, one family physician will nearly $1.5 million a year on behalf of his or her affiliated hospital, as indicated in Section I. This works out to over $124,000 of revenue lost for each month an open family physician position goes unfilled. Of course, the impact in terms of lives that may be saved or enhanced by having a family physician in place cannot be quantified. Cost containment is a critical issue for most hospitals today, but saving a few thousand dollars on physician recruitment can cost hundreds of thousands of dollars in the long run. Board members can positively influence the physician recruitment process by ensuring that their hospitals make the financial commitment necessary to success.

**Step Four: Strategic Staff Plan**

Physician recruitment should be a proactive effort rather than a reactive one. A strategic medical staff plan allows a hospital to map out its physician recruiting needs over a one to five year period based on objective data. The hospital can then anticipate its physician staffing needs rather than reacting to sudden losses to
the staff. A medical staff plan can be a vital recruiting tool because it demonstrates to physician recruits that there is a legitimate need in the community for their services. It also may convince physicians on the staff to support the search by showing them objective evidence that recruitment is necessary. Getting the medical staff to buy into recruitment is essential, because unsupportive physicians can undermine even the most well-structured and executed search.

The medical staff plan should include a thorough count of all full-time-equivalent physicians within the hospital’s service area. There are several studies providing ratios suggesting how many physicians in various specialties are needed per 100,000 people that can be incorporated into the plan. An analysis of patient demographics, physician demographics, and local disease incidence will help demonstrate the need for specific physician specialties, as will a survey of the existing medical staff asking them what recruitment needs they see.

A growing, aging population, a relatively high incidence of disease, aging or retiring physicians, a physician deficit based on suggested physician to population ratios, long patient referrals times, patient migration and other factors will all point to needs in the community. A completed plan will provide a blueprint for what types of physicians are needed, why they are needed, and when they are needed. With this rationale in hand, the hospital can proceed on a proactive, informed basis to the next step in the recruiting process.

**Step Five: Compliance**

Board members should be aware that hospitals must comply with federal guidelines when recruiting physicians. These guidelines specifically call for hospital Board oversight of the physician recruiting process. It is prudent to draft a Hospital Board Resolution on Physician Recruitment stating the hospital’s intention to follow the rules. There are a variety of practices the hospital should pledge to avoid, including any type of payment made to new recruits for patient referrals to the hospital. The hospital also should not recruit physicians already in the community (with the exception of medical residents) or pay physicians beyond what is “reasonable” for their specialty.

Board members should ensure that these and other rules are strictly followed, as violation of federal physician recruiting guidelines can lead to loss of a hospital’s tax exempt status, exclusion from Medicare/Medicaid, and civil and criminal penalties.

The medical staff plan is very important in this regard. Federal physician recruiting guidelines indicate that in order to provide physicians with certain recruiting incentives, hospitals should demonstrate that there is a need for the physician in the community. The medical staff plan confirms community need and therefore serves as a key compliance document hospitals may use to justify their physician recruiting activities.

It also is important to have physician recruiting contracts reviewed by an attorney experienced in physician recruiting related laws and regulations.
Step Six: The Recruiting Team

There are a number of stakeholders in physician recruiting who should be gathered into a cohesive team. The team should include one to two Board members, staff physicians, the physician recruiter, administrators of local medical groups, and hospital department representatives. The head of the team and the final decision maker should be the hospital CEO. CEO involvement is crucial because it demonstrates to candidates the hospital’s high level of commitment to the process. In addition, one person must have the final word on contracts, candidate parameters, and other issues, and only the CEO carries the necessary authority.

The recruiting team will approve candidate parameters, the incentive package, ensure compliance, review candidate CVs, participate in interviews, and in the closing process. It is essential that clear lines of communication are established within the team so that information can be relayed in a timely manner and decisions can be made promptly.

Step Seven: Opportunity Analysis

Before seeking candidates for a particular opening, a written analysis of the opportunity should be prepared. The recruiter working on the search (whether in-house or with an agency) must know exactly what they are selling, just as any salesman must know the ins and outs of his or her product. Among other things, physicians will ask:

- Why is the hospital recruiting?
- Nursing staff available?
- What is its strategic direction?
- What is the payer mix?
- Potential physician colleagues?
- Collection rate?
- Hours/call coverage?
- Overhead?
- Medical staff politics?
- Patient volume?
- Path to partner?
- Type of procedures?
- Non-competes?
- Financial incentives?
- Malpractice?

The recruiter must “walk in the physician’s shoes” and make a candid, objective evaluation of the opportunity, to understand its strengths and weaknesses, and commit the opportunity profile to writing. The same procedure should be followed in examining the community, with a focus on the life style amenities that current
members of the staff enjoy.

The recruiter must have enough training, knowledge and savvy to speak on a physician’s level about a wide range of practice issues. As referenced earlier, physicians commonly are seeking a better practice environment, so recruiters must know how to analyze a practice opportunity and present the opportunity in a way that appeals to physicians. This comes down to the aptitude of the individual recruiter. Board members can advance the hospital’s cause by evaluating whether or not physician recruiters have the personal and professional qualities needed to succeed in what is essentially a high level sales position.

Step Eight: Candidate Parameters

There are two things hospitals can do that will immediately enhance their prospects of physician recruiting success. One is to consider older physician candidates. The other is to consider internationally trained physicians. Unfortunately, many hospitals jeopardize their recruitment chances by insisting on very narrow candidate parameters. For some hospital executives, the ideal candidate remains a young, Ivy League trained physician with movie star looks.

As discussed earlier, over one third of practicing physicians in the U.S. are 56 or older and about one-fourth are international medical graduates. By excluding these groups from consideration, hospitals can easily dismiss well over 50% of the potential candidates available in a particular specialty. In today’s environment, that is a recipe for failure.

A better approach is to focus on the qualities the hospital really needs in a physician, i.e., good training, a positive bedside manner, a strong work ethic, and a desire to join the community. The recruiting team should put these parameters in writing and agree to make an offer to the first physician who fits the agreed upon profile. This is essential to avoid the “comparison shopping” that derails many physician search efforts. Consider that while the hospital keeps one suitable candidate on hold as it looks for someone just a bit more dynamic, that candidate is hearing from other persuasive suitors. The typical result is the hospital fails to secure any of the candidates it is juggling.

Step Nine: The Incentive Package

The rule of thumb in crafting an incentive package is simple: “be competitive.” Physicians generally are not “chasing money” when they seek a practice, but money in the form of many different offers generally is chasing them. They know what is competitive in today’s market, so an incentive package has to reflect market realities in order to attract physician interest. There are a number of physician compensation surveys (including Merritt, Hawkins’ annual Review of Physician Recruiting Incentives – see www.merrithawkins.com) that can be used to tailor a competitive physician incentive package.
These surveys can be referenced to determine prevailing salary ranges in various specialties. For example, below are salary ranges for family physicians referencing several physician income surveys.

<table>
<thead>
<tr>
<th>Average Income for Family Physician</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>American Medical Group Association</td>
<td>$226,000</td>
</tr>
<tr>
<td>Compdata</td>
<td>$222,000</td>
</tr>
<tr>
<td>ECG Management</td>
<td>$223,000</td>
</tr>
<tr>
<td>Merritt Hawkins</td>
<td>$225,000</td>
</tr>
<tr>
<td>Sullivan Cotter</td>
<td>$250,000</td>
</tr>
</tbody>
</table>

Of growing importance is not just the salary amount offered to physicians, but the way income is structured and how physicians are rewarded. Most physician contracts today feature a base salary and a production bonus. The bonus may be predicated on a variety of volume-based metrics, such as number of patients seen, amount of revenue collected, or number of relative value units (RVUs) generated per doctor. However, physicians also may earn bonuses by meeting certain quality standards, by achieving high scores on patient satisfaction surveys, through governance responsibilities, community outreach, and peer review.

Many bonus systems use a formula which accounts for several of these metrics simultaneously to establish a more balanced compensation structure. More information on this subject is included in Merritt Hawkins’ white papers *Performance-Based Physician Compensation* and *RVU Based Physician Productivity and Compensation*.

Equally important is that a contract or letter of agreement be available *prior to any candidate interviews*. Searches frequently become untracked because no contract or general letter of agreement is available for candidates to evaluate. Without such a document, candidates have no way of making a commitment to an opportunity and the process seems vague and undefined. Trustees should ensure that some form of contractual document is ready on the front end of the search.

**Step Ten: Candidate Sourcing**

After completing this initial groundwork, the hospital is ready to activate the search for candidates. The process to this point may have been laborious, but much has been achieved. The hospital:

- Has a staff plan in place
- Is compliant with federal physician recruiting guidelines
- Has a cohesive recruiting team
- Knows the strengths and weaknesses of its “product”
- Knows who it is looking for
- Is offering a competitive incentive package
- Has a contract or letter of agreement ready
- It is only at this phase of the “iceberg” that the process of seeking candidates begins

One key Board members should consider is that the hospital should always be looking for appropriate candidates. This means developing a positive relationship with statewide residency programs, “working” the existing medical staff for referrals, and grooming young people in the community for careers in medicine.

In addition, hospitals should employ a variety of candidate sourcing techniques, including postings on physician employment sites, journal advertising, personal letter campaigns, and attendance at physician conventions, thereby casting as wide a net as possible. Social media venues such as LinkedIn, Facebook and Twitter are gaining importance as candidate sourcing tools for younger physicians.

Board members should be particularly attuned to the effectiveness of the hospital’s web site as a recruiting tool. Does it offer a section dedicated to physician recruiting? This section may include all of the key amenities of medical practice in the area. It also should include testimonials from physicians on staff regarding why they enjoy practicing in the area. Video testimonials are particularly effective, as little carries as much weight with candidates as the perspective of physicians already practicing in the community.

Board members with contacts at the local Chamber of Commerce may wish to enlist the Chamber’s support. Today’s candidates will go online to research the amenities of communities they are considering. The Chamber’s web site should be consistent with information listed on the hospital’s site, and should include a feature directed at health care professionals.

A key candidate sourcing tool that often is underutilized is the telephone. At some point, recruiters must pick up the phone and call prospects, as daunting as that may be. In today’s market, hospitals cannot always rely on the Internet or other methods to bring in physician candidates. Instead, recruiters must reach out to physicians, and that means calling them when they are available to talk – after regular business hours and on the weekend. That is the “work in the trenches” that many recruiters are reluctant to do, but it is a necessary part of the process.

To evaluate the hospital’s recruiting efforts, Board members should inquire about recruiter activity. What sourcing methods are they using? How much time do they spend on the phone seeking candidates, how many interviews are they scheduling, and what percentage of interviews lead to placements? Board members can be important to ensuring that the hard work of physician recruiting is being done.

**Step Eleven: Candidate Screening**

Once potential candidates have been identified, they must be thoroughly screened by telephone before an interview is scheduled. The cost in time, effort and money is considerably reduced by a thorough screening
process, which eliminates inappropriate candidates and reduces unproductive interviews.

This is a meticulous process that requires hours of telephone time spent by the recruiter with the candidate and his or her spouse. Involving the spouse is critical, because he or she often has equal or even final say in the decision. The key is for the recruiter to identify the physician’s motivation for seeking a practice. What sort of environment does the physician desire and can the hospital’s opportunity meet his or her needs?

The recruiter should develop a written profile of the candidate, specifying the candidate’s background, current practice situation, personal interests, family situation, and motivation for seeking a new practice. The profile should include similar information about the spouse – particularly the spouse’s need for employment, if any. The information should be shared with Board members on the recruiting team and others prior to scheduling interviews.

**Step Twelve: The Interview**

The key to successful candidate interviews is to understand what the interview is for. The interview should be for confirmation, not exploration. When the interview is properly arranged, the candidate will already know the terms of the offer, the call schedule in the practice, payer mix, work hours, anticipated patient volume, path to partnership, and associated details. In turn, the hospital will know the candidate’s professional background, personal interests, family situation, etc.

When a thorough candidate screen is conducted, the interview becomes a chance for the two parties to connect on a personal basis, rather than a forum for information gathering or negotiation. For this reason, the interview should be structured to be 70% social and 30% business. It is imperative that the spouse be on the interview. If not, the interview should be rescheduled.

A written interview itinerary should be prepared for the physician and spouse that includes a tour of the hospital, the community, the clinic or medical group, and meetings with physicians in the candidate’s specialty, referring physicians, the hospital CEO and Board members on the recruiting team. The interview is an opportunity to prove to the candidate the validity of everything that has been discussed hitherto and to determine if the all stakeholders involved are personally and professionally compatible.

**Step Thirteen: Closing**

Many resources have been invested in the recruiting process to reach this point, and the process cannot be put on hold indefinitely while the candidate makes a decision. During the interview candidates should be told that a timely decision is expected so that, one way or the other, the recruitment process can remain on track.
The first 48 hours after the interview are critical. This is the point at which the candidate’s interest is at its highest. All the groundwork pays dividends here, since the candidate has all the information he or she needs to make a decision. However, if the candidate should require more information, the recruiting team is structured to respond to candidate requests in a timely matter. All negotiating points have been covered – the candidate simply has to determine whether the opportunity matches his or her needs.

The hospital can make the decision easier by follow-up calls from the CEO and staff physicians stressing how glad they were to meet the physician and how much they look forward to having him in the community. Recruitment at this point often comes down to how wanted to the candidate feels. If he is deciding between multiple opportunities, the hospital that offered the most personal approach and went the extra mile to be accommodating usually wins out.

**Step Fourteen: Follow Up**

Even if the physician signs a contract committing to the opportunity, there is still work to be done. The hospital must stay in continual contact, assisting the doctor with licensure, credentialing and relocation. Some hospitals lose energy once the initial courting process is over, which can lead to candidate fall off. Nothing is secure until the candidate is in the community, seeing patients. At that point, the recruitment phase transitions into the retention phase, and the ongoing process of maintaining a full, loyal, and productive medical staff continues.

While Board members typically are not involved in the day-to-day process of physician search, they play a key role in ensuring that their facilities are positioned for consistent recruiting success. They can do so by establishing a sense of urgency and commitment, by ensuring appropriate resources are available, and by insisting on a strategic, ongoing and sequential recruiting plan.
About Merritt Hawkins

Established in 1987, Merritt Hawkins is the leading physician search and consulting firm in the United States and is a company of AMN Healthcare (NYSE: AHS), the largest healthcare workforce solutions organization in the nation. Merritt Hawkins’ provides physician and advanced practitioner recruiting services to hospitals, medical groups, community health centers, telehealth providers and many other types of entities nationwide.

The thought leader in our industry, Merritt Hawkins produces a series of surveys, white papers, books, and speaking presentations internally and also produces research and thought leadership for third parties. Organizations for which Merritt Hawkins has completed research and analysis projects include The Physicians Foundation, the Indian Health Service, Trinity University, the American Academy of Physician Assistants, the Association of Academic Surgical Administrators, and the North Texas Regional Extension Center.

This is one in a series of Merritt Hawkins’ white papers examining a variety of topics directly or indirectly affecting the recruitment and retention of physicians and advanced practice professionals, including physician assistants (PAs) and nurse practitioner (NPs).

Additional Merritt Hawkins’ white papers include:

- Physician and Hospital Reimbursement: From “Lodge Medicine” to MIPS
- Telehealth: The Integration of Telecommunication into Patient/Provider Encounters
- Population Health Management and Physician Staffing
- Convenient Care: Growth and Staffing Trends in Urgent Care and Retail Medicine
- Psychiatry: “The Silent Shortage”
- The Aging Physician Workforce: A Demographic Dilemma
- Nurse Practitioners and Physician Assistants: Supply, Distribution, and Scope of Practice Considerations
- The Physician Shortage: Data Points and State Rankings
- Physician Supply Considerations: The Emerging Shortage of Medical Specialists
- The Economic Impact of Physicians
- Ten Keys to Physician Retention

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